STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	C 11/18/2022

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WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/15/22 through 11/18/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OZVG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/15/22 through 11/18/22. Event ID# OZVG11. The following intakes were investigated: NC00192190, NC00192043, NC00191551, NC00190941, NC00190952, NC00189090, NC00188461, NC00186917 and NC00186626. 1 of the 26 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 637 SS=B	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Minimum Data Set	F 637	Willow Creek Nursing and Rehabilitation acknowledges receipt of the Statement of	12/22/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/16/2022

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F 637	Continued From page 1 (MDS) Significant Change in Status Assessment (SCSA) within 14 days of determination of Hospice election for 2 of 2 residents reviewed for Hospice (Resident #97 and Resident #37). Findings included: 1. Resident #97 had been readmitted on 2/8/2022. An order for Hospice to evaluate and treat Resident #97 was written on 2/9/2022. A note written by Social Worker (SW) #1 on 2/9/2022 at 10:58 AM indicated the family was meeting with Hospice this morning to complete the Hospice paperwork. A SCSA dated 2/15/2022 indicated Resident #97 was receiving Hospice services. The assessment was noted as completed on 3/1/2022. On 11/17/2022 at 2:10 PM an interview with MDS Nurse #3 was conducted. She stated she had not been aware that SCSA needed to be completed within 14 days of the determination of a change. On 11/17/22 at 3:27 PM an interview with the Administrator was conducted. She stated staff were not aware it was a requirement for SCSA to be completed within 14 days of determination of a significant change. She explained this would be corrected going forward. 2. Resident #37 was admitted to the facility on 2/5/13. An order for Hospice to evaluate and treat Resident #37 was written on 10/31/22. Review of Resident #37's Minimum Data Set	F 637	Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Willow Creek Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Willow Creek Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F637 Comprehensive Assessment After Significant Change On 3/1/2022, the Minimum Data Set Nurse (MDS) completed resident #97 MDS assessment for significant change related to hospice services. On 11/11/2022, the MDS nurse initiated MDS assessment for resident #37 for significant change related to hospice services and the assessment was completed on 11/18/22. On 12/16/2022, the MDS Consultant initiated an audit of all residents MDS	

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F 637	Continued From page 2 assessments conducted on 11/16/22 revealed an in progress Significant Change in Status Assessments (SCSA) dated 11/11/22. On 11/17/2022 at 2:10 PM an interview with MDS Nurse #1 was conducted. She stated she had not been aware that SCSA needed to be completed within 14 days of the determination of a change, such as starting to receive Hospice. On 11/17/22 at 3:27 PM an interview with the Administrator was conducted. She stated staff were not aware it was a requirement for SCSA to be completed within 14 days of determination of a significant change, such as starting to receive Hospice. She explained this would be corrected going forward.	F 637	assessments for significant change to include resident #97 and resident #37 and residents receiving hospice services. This audit is to ensure assessments were completed within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition to include but not limited to residents receiving hospice services. The Director of Nursing (DON) and MDS consultant will address all concerns identified during the audit. Audit will be completed by 12/22/2022. On 11/17/2022, the MDS consultant completed an in-service with the MDS nurse regarding MDS Assessment for Significant Change with emphasis on ensuring assessment is completed within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. All newly hired MDS nurses will be in-serviced during orientation regarding MDS Assessment for Significant Change. The Quality Assurance (QA) Nurse will audit all new MDS assessments related to significant change to include assessments for resident #97 and resident #37 weekly x 4 weeks then monthly x 1 month utilizing the MDS Audit Tool. This audit is to ensure assessments were completed within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental	

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F 637	Continued From page 3	F 637	condition to include but not limited to residents receiving hospice services. The QA Nurse will address all concerns identified during the audit to include completion of the assessment and/or re-training of staff. The DON will review the MDS Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the MDS Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the MDS Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further frequency of monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		12/22/22

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F 657	Continued From page 4 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and interview with Dialysis Treatment Center staff, the facility failed to revise the care plan for 1 of 1 resident reviewed for dialysis. (Resident # 128) Findings included: Resident #128 was admitted to the facility on 9/22/2022 with diagnoses including end stage renal disease. The admission Minimum Data Set (MDS) assessment dated 9/29/2022 indicated Resident #128 was moderately cognitively impaired and received dialysis. The revised care plan dated 10/5/2022 revealed Resident #128 received dialysis on Monday, Wednesday and Friday. Interventions included communicating with the Dialysis Treatment Center as indicated for adjustments in Resident #128's care and/or treatment plan.	F 657	F657 Care Plan Timing and Revision On 11/18/22, the Minimum Data Set Nurse (MDS) revised resident #128 care plan to include receiving dialysis 5 days per week. On 12/16/22, the Nursing Supervisor initiated an audit of all current residents to include resident #128 to ensure care plans accurately reflect dialysis treatment to include days of treatment. The Nursing Supervisor will address all concerns identified during the audit to include updating care plan when indicated and education of staff. The audit will be completed by 12/16/2022. On 12/16/2022, the facility consultant initiated an in-service with the Minimum Data Set Nurse (MDS) regarding Care Plan Revisions with emphasis on	

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F 657	Continued From page 5 On 11/17/2022 at 10:53 a.m. in an interview with Nurse #1, she stated Resident #128 was unable to tolerate four hours in the dialysis chair three times a week and went to Dialysis every day for two hours Monday through Friday. On 11/18/2022 at 9:39 a.m. in an interview with the Dialysis Treatment Center Nurse #1, she stated Resident #128 had been receiving dialysis five days a week Monday through Friday for two hours daily for the last three weeks. On 11/18/2022 at 2:46 p.m. in an interview with MDS Nurse #1, she stated Resident #128 receiving dialysis five days a week instead of three days a week as ordered was discussed in an interdisciplinary team (IDT) morning meeting and was unsure why Resident #128's care plan was not updated after the IDT morning meeting. She stated Resident #128 was not one of her assigned residents; Resident #128 was assigned to the MDS Nurse #2. On 11/18/2022, MDS Nurse #2 was not available for interview. On 11/18/2022 at 2:59 p.m. in an interview with the Scheduler, she stated she was informed by the Dialysis Treatment Center to start scheduling Resident #128 to the center daily Monday through Friday on November 8, 2022 until further notice. On 11/18/2022 at 3:43 p.m. in an interview with the Director of Nursing, she stated due to Resident #128 being frigidity, dialysis appointments were decreased to two hour visits Monday through Friday and was discussed during an IDT morning meeting. She stated Resident	F 657	responsibility of the MDS nurse to ensure care plan revisions are accurately completed and reflect dialysis treatment to include days of treatment. The in-service will be completed by 12/22/2022. After 12/22/2022 (same date of completion), any MDS nurse who has not completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired MDS nurses will be in-serviced during orientation regarding Care Plan Revisions. The Minimum Data Set Director (MDS) will review care plans for residents receiving dialysis to include resident #128 weekly x 4 weeks then monthly x 1 month utilizing the Dialysis Audit Tool. This audit is to ensure care plans are accurately reflect dialysis treatment to include days of treatment. All concerns identified during the audit will be addressed by the Quality Assurance Nurse (QA) Nurse to include revision of care plans to reflect dialysis treatment and/or re-education of staff. The Director of Nursing will review the Dialysis Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of Dialysis Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Dialysis Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and	

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F 657	Continued From page 6 #128's care plan should had been updated to communicate the change in his dialysis treatment plan.	F 657	/ or frequency of monitoring.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews, the facility failed to administer the tube feeding formula at the correct rate as ordered by the physician and label the tube feeding formula with a date and time when opened for use for 1 of 1 resident (Resident #64) reviewed for tube feedings.	F 693	F693 Tube Feeding Mgmt/ Restore Eating Skills On 11/18/22, resident #64 tube feeding rate was decreased from 55mL/hr to 50 mL/hr by nurse #4 per physician□s order. Nurse #4 dated/timed feeding bag to accurately reflect when bag was opened	12/22/22

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F 693	Continued From page 7 Findings included: Resident #64 was admitted to the facility on 7/27/2016. The quarterly Minimum Data Set (MDS) assessment dated 8/2/2022 indicated Resident #64 received tube feedings for nutrition for greater than 51% of total calories. Dietary notes dated 11/8/2022 revealed Resident #64 was receiving an enteral feeding at 55 milliliters(mL) per hour(hr) and a plan to decrease enteral feeding to 50 mL/hr for weight management. Physician orders dated 11/8/2022 revealed an order for Diabetasource, an enteral feeding, every twenty-four hours at 50 mL/hr, and Nurse #10 acknowledged the order on 11/8/2022. On 11/18/2022 at 2:54 p.m. in an interview with Nurse #10, she stated she was working as the unit manager on 11/8/2022 and acknowledged and signed offed the physician order dated 11/8/2022 to decrease Resident #64's enteral feeding to 50 mL/hr and entered the order into the electronic MAR. She stated she did not decrease the enteral feeding to 50 mL/hr, and she was unable to recall the nurse assigned to Resident #64 she told to decrease the enteral feeding to 50mL/hr. There was no nursing documentation revealing the enteral feeding was decreased to 50mL/hr on 11/8/2022. A review of the November 2022 Medication Administration Record (MAR) revealed the day	F 693	per facility protocol. On 11/17/2022, the DON initiated an audit of all residents receiving continuous tube feeding to ensure the feeding was being administered at the correct rate as ordered by the physician and that the nurse labeled tube feeding formula with the correct date and time opened for use, and documentation in the progress note of tube feeding order changes. The Unit Managers will address all concerns identified during the audit to include correcting rate of tube feeding administration per physician□s order, correcting labeling of tube feeding formula, and/or staff education. The audit will be completed by 11/18/2022. On 11/18/2022, the DON initiated an in-service with all nurses to include nurse #4, nurse #7, nurse #8, nurse #9, and nurse #10 regarding Tube Feeding Management with emphasis on ensuring correct rate of tube feeding administered per physician□s order, labeling tube feeding formula with correct date and time opened for use, and documentation in the progress note of tube feeding order changes. The in-service will be completed by 12/22/2022. After 12/22/2022, any nurse who has not completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired licensed nurses will be in-serviced during orientation regarding Tube Feeding Management. The Unit Managers will audit all residents	

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F 693	Continued From page 8 shift nursing staff verified Resident #64's continuous enteral feeding, Diabetasource, was infusing at 50 mL/hr every 24 hours from 11/8/2022 to 11/16/2022. The care plan dated 11/10/2022 revealed Resident #64 required a feeding tube for nutritional improvement and maintenance. Interventions included administering tube feeding formula as ordered by the physician. On 11/15/2022 at 10:24 a.m., the enteral feeding, Diabetasource, was observed infusing at 55 mL/hr. There was no resident name and no date and time the eternal feeding formula was opened for infusion observed on the enteral formula bag. On 11/15/2022 at 10:29 a.m. in an interview with Nurse #7, she stated Resident #64 received continuous enteral feedings and received two bags of formula a day. She stated the enteral formula bag that was hanging was started by the night shift (7 p.m. to 7 a.m.), and the nurse starting a new bag of enteral formula was to write the Resident #64's name, room number, date and time the enteral formula was started and the rate of the enteral feeding on the enteral formula bag. On 11/15/2022 at 10:30 a.m. after checking Resident #64's electronic medical record, Nurse #7 was observed writing 11/14/2022 and 9 p.m. on Resident #64's enteral formula bag that was infusing at 55mL/hr. On 11/17/2022 at 7:22 a.m. prior to a medication pass observation, Resident #64's enteral feeding was observed infusing at 55mL/hr. Nurse #4 was observed stopping the enteral feeding to administer Resident #64's medications and	F 693	requiring continuous tube feeding to include resident #64 weekly x 4 weeks then monthly x 1 month utilizing the Tube Feeding Monitoring Tool. This audit is to ensure correct rate of tube feeding is administered per physician□s order, labeling tube feeding formula with correct date and time opened for use, and documentation in the progress note of tube feeding order changes. All concerns identified during monitoring will be addressed by the Unit Managers to include correcting rate of tube feeding administration per physician□s order, labeling tube feeding formula with correct date and time opened for use, and/or education of staff. The Director of Nursing will review the Tube Feeding Monitoring Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of Tube Feeding Monitoring Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Tube Feeding Monitoring Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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restarting the enteral feeding at 55 mL/hr after medication administration.

On 11/17/2022 at 7:22 a.m., the physician order on the electronic MAR was reviewed with Nurse #4. Nurse #4 stated the enteral feeding was decreased to 50 mL/hr on 11/8/2022 and stated, "what is she set at". Nurse #4 was observed re-entering Resident #64's room and changing the enteral feeding rate from 55 mL/hr to 50 mL/hr.

On 11/17/2022 at 10:10 a.m. in an interview with Nurse #4, she stated each nurse was responsible for checking that the enteral feeding was infusing per physician's orders. She stated Resident #64's enteral feeding was infusing at 50 mL/hr yesterday (11/16/22) and she documented on the MAR Resident #64's enteral feeding was infusing at 50mL/hour and did not know why the enteral feeding was set at 55 mL/hr this morning.

On 11/18/2022 at 10:55 a.m. in a phone interview with Nurse #8, she stated the nurse acknowledging the physician order should had decreased the enteral feeding for Resident #64. In a follow up phone interview on 11/18/2022 at 11:00am, Nurse #8 stated she gave Resident #64 her medications on 11/14/2022 during the 7p.m. and 7a.m. shift and did not hang the enteral feeding because was there was 300mL left in the enteral formula bag. She stated Nurse #9, who worked the 11 p.m. to 7 a.m. shift, would have started the enteral feeding for Resident #64 on 11/14/2022. She stated the infusion rate of the enteral feeding was automatically set on the machine and was unable to recall Resident #64's infusing rate.

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F 693	Continued From page 10 Attempts to reach Nurse #9 were unsuccessful. On 11/18/2022 at 3:43 p.m. in an interview with the Director of Nursing, she stated when a new enteral feeding bag was started, nurses were to write the date and time the enteral bag was started and the nurse's initials. She further stated Resident #64 should have been receiving the enteral feeding at 50 mL/hr per physician orders.	F 693		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to remove a peripheral intravenous catheter at the completion of therapy for 1 of 1 resident (Resident #98) whose records were reviewed for intravenous therapy. Findings included: The facility's policy "Removal of a Peripheral IV Catheter" lasted revision dated June 2020 stated a catheter should be removed when therapy is completed. Resident #98 was admitted to the facility on 8/3/022. Physician orders revealed an order dated 11/10/2022 read in part "sodium chloride solution	F 694	F694 Parenteral/ IV Fluids On 11/16/22, peripheral intravenous catheter (IV) was removed from left hand of resident # 98 by hall nurse per physician□s order. On 11/16/2022, the Director Of Nursing (DON) initiated an audit of all residents with orders for IV therapy for the past 14 days to ensure IV catheter was removed following treatment per physician orders and facility protocol. The DON will address all concerns identified during the audit to include removing IV catheter when indicated and education of the staff. Audit will be completed by 11/16/2022.	12/22/22

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F 694	Continued From page 11 0.9% use 75milliters (ml)/hour for one liter intravenously one time." Review of the Medication Admission Record (MAR) dated 11/10/2022 showed sodium chloride solution 0.9% use 75ml/hour intravenously one liter was administered. On 11/16/2022 at 9:10 A.M., Resident #98 was observed to have a yellow peripheral venous catheter inserted in the back of her left hand. The site was not labeled with nursing initials, date, or time. An interview was conducted with Nurse #4 on 11/16/2022 at 1:45 P.M. Nurse #4 indicated she observed Resident #98 to have an IV (intravenous peripheral catheter) in her left hand when she began her shift. She indicated the IV site was not red, swollen, or warm on assessment. She indicated the IV should have been removed when Resident #98's sodium chloride solution had finished and there were no orders for lab work to be collected. Physician orders revealed an order start date 11/16/2022 at 2:30 P.M. read in part "discontinue IV from left hand." An interview was conducted the Director of Nursing (DON) on 11/18/2022 at 8:24 A.M. During the interview, she indicated staff were responsible to ensure peripheral catheters were removed at the end of therapy.	F 694	On 12/16/2022, the DON initiated an in-service with all nurses to include nurse #4 regarding Removal of Peripheral IV Catheter with emphasis on removing catheter when therapy is completed and/or per physician order. In-service will be completed by 12/22/22. After 12/22/22, any nurse who has not received the education will complete prior to next scheduled work shift. All newly hired nurse will be educated during orientation regarding Removal of Peripheral IV Catheter. The Unit Managers will audit all residents receiving IV therapy to include resident #98 weekly x 4 weeks then monthly x 1 month utilizing the IV Catheter Audit Tool. This audit is to ensure the nurse removed the IV catheter when IV therapy was completed and/or per physician order. The Unit Managers will address all concerns identified during the audit to include removing catheter per physician order and/or facility protocol and re-education of staff. The Director of Nursing will review the IV Catheter Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of IV Catheter Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the IV Catheter Audit Tool to determine trends and / or issues that may	

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F 694	Continued From page 12	F 694	need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain a physician order when the dialysis treatment plan changed for 1 of 1 sampled resident reviewed for dialysis (Resident #128). Findings included: Resident #128 was admitted to the facility on 9/22/2022 with diagnoses including end stage renal disease. The care plan dated 9/23/2022 revealed Resident #128 received hemodialysis for end stage renal disease three times a week on Monday, Wednesday and Friday. Interventions included communicating with the dialysis treatment center, assessing the resident upon return from dialysis and monitoring vital signs. The admission Minimum Data Set (MDS) assessment dated 9/29/2022 indicated Resident #128 was moderately cognitively impaired and received dialysis.	F 698	F698 Dialysis On 11/18/2022, the Unit Manager clarified and updated the order for dialysis treatment for resident #128. On 12/16/2022, the Nursing Supervisor initiated an audit of all residents receiving dialysis to include resident #128 to ensure the resident electronic record contained an order for dialysis treatment to include days of the week of treatment. The Director Of Nursing (DON) will address all concerns identified during the audit to include clarifying order for dialysis with the physician and updating order for dialysis to include days of the week and education of the staff. Audit will be completed by 12/16/2022. On 12/16/2022, the DON initiated an in-service with all nurses regarding Dialysis Orders with emphasis ensuring residents who receive dialysis have a	12/22/22

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F 698	Continued From page 13 A review of the physician progress notes dated 10/21/2022 revealed Resident #128 was receiving dialysis treatments on Monday, Wednesday and Friday. A review of the faxed Dialysis Treatment Center orders log sheet dated 11/1/2022 revealed to start hemodialysis treatments five days per week for two hours. Physician orders dated 11/8/2022 revealed Resident #128 was ordered dialysis on Monday, Wednesday and Friday. In an interview with the Scheduler on 11/18/2022 at 2:59 p.m., she stated she was informed by the Dialysis Treatment Center to schedule Resident #128 daily for dialysis Monday through Friday until further notice, and Resident #128 had been scheduled Monday through Friday two-hour dialysis appointments since November 8, 2022. In an interview with Nurse #1 on 11/17/2022 at 10:53 a.m., she stated Resident #128 was receiving dialysis daily Monday through Friday for two hours because Resident #128 was unable to sit in the dialysis chair for the usual four-hour requirement. In a phone interview with Dialysis Treatment Center Nurse #1 on 11/18/2022 at 9:39 a.m., she stated Resident #128's dialysis treatment plan changed three weeks ago from receiving dialysis on Monday, Wednesday and Friday to Monday through Friday for two hours. In an interview with Nurse #11 on 11/18/2022 at 1:52 p.m. assigned to Resident #128, she stated	F 698	physician order for dialysis treatment to include but not limited to the days of the week of treatment and that the care plan is updated to accurately reflect dialysis treatment. The in-service will be completed by 12/22/2022. After 12/22/2022, any nurse who has not completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired MDS nurses will be in-serviced during orientation regarding Dialysis Orders. The Unit Managers will review orders for all residents receiving dialysis to include resident #128 weekly x 4 weeks then monthly x 1 month utilizing the Dialysis Audit Tool. This audit is to ensure each resident receiving dialysis has a physician order for dialysis treatment to include but not limited to days of the week for treatment and that the care plan accurately reflect dialysis treatment to include days of treatment. All concerns identified during the audit will be addressed by the Unit Managers to include clarifying and updating order for dialysis to include days of the week for treatment, updating care plan to reflect dialysis treatment and/or re-education of staff. The Director of Nursing will review the Dialysis Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of Dialysis Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly	

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F 698	Continued From page 14 Resident #128 had received dialysis since admission, and the physician order for dialysis was for Monday, Wednesday and Friday. In an interview with the Director of Nursing on 11/18/2022 at 2:59 p.m., she stated due to Resident #128 not tolerating the dialysis chair for four hours, his dialysis appointments were changed to Monday through Friday for two hours. She stated the facility was notified by the Dialysis Treatment Center of the change in dialysis appointments, and the change was discussed in the interdisciplinary meeting. She stated Resident #128's assigned nurse, or the unit manager should have obtained a verbal order from the physician to communicate the change in Resident #128's dialysis treatment plan. She stated she was unable to recall when the change in Resident #128's dialysis occurred, or the nurse assigned to Resident #128 during that time.	F 698	x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Dialysis Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		12/22/22

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F 756	Continued From page 15 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Pharmacist interviews, the facility failed to act upon repeated pharmacy recommendations to assess for abnormal involuntary movements and laboratory tests for a resident receiving daily antipsychotic medications for 1 of 5 residents (Resident #32) reviewed for unnecessary medications. Findings included: Resident #32 was admitted to the facility on 6/11/2021 with diagnoses including schizophrenia and Diabetes Mellitus.	F 756	F756 Drug Regimen Review On 11/2/2022, the Quality Assurance (QA) Nurse completed a DISCUS Assessment for resident #32 per pharmacy recommendation and facility protocol. The physician was updated on assessment findings. On 11/23/2022, the Hall Nurse clarified with the physician lab orders for resident #32 to include labs for AIC and BMP. Labs were completed on 11/25/2022 per physician orders and pharmacy recommendation.	

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F 756	Continued From page 16 Nursing documentation dated 7/23/2022 revealed Resident #32 displayed sporadic movements, gestures and temperaments in behaviors exhibited. The annual Minimum Data Set (MDS) assessment dated 10/15/2022 indicated Resident #32 was severely cognitively impaired, displayed physical behaviors directed toward others and received antipsychotics routinely and as needed. The care plan dated 11/1/2022 revealed a focus for the use of psychotropic drugs with the potential for side effects of the neuromuscular system. Interventions included administering medications per physician's orders and Dyskinesia Identification System: Condensed User Scale (DISCUS), an assessment of abnormal involuntary movements, evaluation per facility protocol. Physician orders dated 11/8/2022 revealed Resident #32 was receiving Haloperidol Lactate, an antipsychotic medication, 5 milligrams(mg) every eight hours as needed for severe agitation related to schizophrenia and an order dated 10/11/22 for Quetiapine Fumarate, a psychotic medication to treat schizophrenia, 50 mg orally twice a day. a. A review of the Pharmacy Consultant's monthly medication regimen reviews revealed the following nursing recommendations for a DISCUS evaluation for Resident #32: * 8/23/2021: Update DISCUS due to Risperdal Consta, medication used to treat mental disorders. * 9/28/2021: Updated DISCUS due to Risperdal Consta and recent use of intramuscular	F 756	On 11/18/22, the Director of Nursing (DON) initiated an audit of all residents receiving antipsychotic medications. This audit is to ensure a DISCUS assessment was completed per facility protocol and pharmacy recommendation. The QA Nurse will address all areas of concern identified during the audit to include completion of DISCUS assessment per facility protocol and pharmacy recommendation, notification of the physician for any abnormal findings and education of staff. Audit will be completed by 11/21/22. On 12/16/22, the DON/Unit Managers initiated an audit of all pharmacy recommendations for the past 3 months to include but not limited to recommendations for routine lab and discus monitoring. This audit is to ensure pharmacy recommendations were reviewed/completed by nursing and/or the physician with documentation in the electronic record and/or documentation in electronic record if physician declines recommendation. The DON/Unit Managers will address all concerns identified during the audit to include completion of pharmacy recommendations, documentation in electronic record if physician declines recommendations and education of staff. Audit will be completed by 12/22/2022. On 12/16/22, the DON initiated an in-service with all nurses regarding Monitoring Antipsychotic Medications with	

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F 756	Continued From page 17 Haloperidol Lactate. * 10/27/2021: Update DISCUS due to Risperdal Consta and Recent use of Intramuscular Haldol. * 11/28/21: Update due to Risperdal Consta and Latuda, a medication to treat schizophrenia. * 12/30/21: Update due to due to Risperdal Consta and Latuda. * 1/27/2022: Update DISCUS due * 2/22/2022: Update DISCUS due * 3/30/2022: Update DISCUS due * 4/26/2022: Update DISCU due DISCUS assessments dated 5/27/22, 6/23/22, and 9/6/22 all indicated Resident #32 had no abnormal involuntary movements. b. Pharmacy Consultant's monthly medication regimen reviews revealed nursing recommendations for routine labs were due: A1C test, a blood test that measures the average blood sugar level over the past three months, and a basic metabolic panel, test that measures eight different substances in the blood and provided information about the body's chemical balance and metabolism on 12/30/2021, 1/27/2022, 2/22/2022, 3/30/2022 and 4/26/2022. A review of Resident #32's laboratory tests revealed a A1C test was not conducted until 8/4/2022 with an A1C level reported as 7.9. There was no documentation in Resident #32's medical record that a basic metabolic panel test was conducted. On 11/18/2022 at 2:00 p.m. in a phone interview with Pharmacist #1, she stated three copies of pharmacy recommendations were sent to the facility on the first of each month: one copy was sent to the DON. She stated when nursing	F 756	emphasis on completion of DISCUS Assessment upon admission, every 6 months, following changes in antipsychotic medications and per pharmacy recommendations to include documentation in the electronic record and notification of the physician of all abnormal findings. In-service will be completed by 12/22/2022. After 12/22/2022 any nurse who has not completed the in-service will complete prior to next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Monitoring of Antipsychotic Medications. On 12/16/2022, the Administrator initiated an in-service with the Director of Nursing (DON), Assistant Director of Nursing (ADON), QA Nurse, and Nurse Supervisor regarding Pharmacy Recommendations with emphasis on ensuring all pharmacy recommendations to include but not limited to routine lab and DISCUS monitoring are reviewed/completed timely by the nurse and/or physician with documentation of review in the electronic record. In-service will be completed by 12/22/22. After 12/22/22 any DON, ADON or Nurse Supervisor who has not completed the in-service will complete prior to next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Pharmacy Recommendations The DON will audit pharmacy recommendations to include but not	

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F 756	Continued From page 18 recommendations were not completed by the next medication regimen review, pharmacy continued to make the recommendations and conference with the DON as needed if the recommendation was life threatening. She stated DISCUS assessments were not a high priority and pharmacy would not have called the DON when the DISCUS assessments and laboratory tests were not completed. On 11/18/2022 at 3:15p.m. in an interview with Nurse #7, she stated DISCUS assessments were automatically triggered in the electronic medical record and did not know how often DISCUS assessments were performed on residents receiving antipsychotic medication. She stated Resident #32 behaviors were monitored daily, and the physician was notified when a change in her baseline or health status was identified. On 11/18/2022 at 1:40 p.m. in an interview with the Director of Nursing (DON), she stated pharmacy recommendations were emailed to her and provided to the nurse, weekend supervisor or Quality Improvement (QI) Nurse #1 by the fourth of every month to complete. She stated pharmacy sometimes followed up with emails and phone calls when recommendations were not completed. She stated nurses were able to order laboratory tests per pharmacy recommendations and Resident #32's pharmacy recommendations for a DISCUS evaluation and laboratory tests should have been acted on as soon as they were received from the pharmacy. On 11/18/2022 at 1:47 p.m. in an interview with QI Nurse #1, she stated when she received pharmacy recommendations from the DON, she	F 756	limited to recommendations for routine labs and DISCUS monitoring monthly x 2 month utilizing the Pharmacy Recommendations Audit Tool. This audit is to ensure pharmacy recommendations to include but not limited to routine lab and DISCUS monitoring are reviewed/completed by the nurse/physician timely with documentation of review in the electronic record. The DON will address all concerns identified during the audit to include completion of pharmacy recommendation and/or documentation in the electronic record if physician declines recommendation and re-education of staff. The Administrator will review the Pharmacy Recommendations Audit Tool monthly x 2 months to ensure all concerns were addressed. The Administrator will forward the results of the Pharmacy Recommendations Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Pharmacy Recommendations Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 756	Continued From page 19 addressed within one to two days and documented on the printed copy of the nursing recommendation that the recommendations were completed. When asked why Resident #32's DISCUS assessment and laboratory tests recommendations had not been addressed, she stated she assumed the position as QI nurse on 7/12/2022, and the QI nurse prior to her no longer worked at the facility.	F 756		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, staff interviews and pharmacy interviews, the facility failed to provide administration of a prescribed anti-rheumatic medication for 1 of 2 residents reviewed for medication errors. (Resident #13) Findings included: Resident #13 was admitted to the facility on 9/21/2020 with diagnoses including chronic pain. The care plan dated revised on 7/14/2021 revealed Resident #13 had acute and chronic pain related to Rheumatoid Arthritis. Interventions included administering pain medications per physician's orders. A review of the monthly Medication Administration Record (MAR) from February 2022 to November 2022 revealed Methotrexate was not documented	F 760	F760 Residents are Free of Significant Med Errors On 11/17/22, Methotrexate was administered to resident #13 per physician orders. On 12/16/2022, the Director of Nursing (DON) initiated an audit of all resident Medication Administration Records (MARs) from 12/1/22-12/15/22 to ensure all medications were administered per physician order or physician was notified if medication could not be administered for further recommendation with documentation in the electronic record. The DON/Unit Managers will address all concerns identified during the audit to include administering medication per physician order, notification of the physician if medication cannot be	12/22/22

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F 760	Continued From page 20 as administered to Resident #13 on 5/6/2022 and 5/13/2022. Physician orders dated 2/18/2022 revealed the order to inject intramuscularly one milliliter(mL) of Methotrexate Sodium 50 milligrams per 2 mL every Friday was discontinued on 5/18/2022 and was reordered on 5/25/2022 for administration weekly on Wednesdays. The quarterly Minimum Data Set (MDS) assessment dated 10/15/2022 indicated Resident #13 was cognitively intact and required assistance with activities of daily living. The MDS further indicated Resident #13 was frequently in pain, was on a pain regimen and had received one injection during the seven-day look back period. Physician progress notes dated 3/10/2022 and 5/26/2022 revealed Resident #13 was receiving Methotrexate, an anti- rheumatic medication, 25 milligrams intramuscular injections every week for chronic rheumatoid pain. Nursing documentation revealed no reason in Resident #13's medical record why Methotrexate was not documented as administered on 5/6/2022 and 5/13/2022. On 11/16/2022 at 8:53 a.m., during a medication pass, Nurse #4 was observed not administering Methotrexate to Resident #13. Nurse #4 stated the medication was not available on the medication cart to administer to Resident #13, and she would have to reorder the medication from the pharmacy. Nurse #4 obtained a new physician order for Methotrexate and documented administered to Resident #13 on 11/17/2022.	F 760	administered for further recommendation and education of the staff. The audit will be completed by 12/22/2022. On 12/16/2022, the DON initiated an audit of all medication carts/medication supply compared to current MARs to ensure medications were available to administer per physician orders. The Unit Managers will address all concerns identified during the audit to include obtaining medications from pharmacy when indicated, notification of the physician if medications cannot be administered per physician order for further recommendations and education of the nurse. Audit will be completed by 12/22/2022. On 12/16/2022, the DON initiated an in-service with all nurses regarding Following Physician Orders with emphasis on the nurse□s responsibility to order/reorder all medications timely to ensure medications are available to administered per physician order and/or notification of the physician if medication does not arrive timely, cannot be obtained through the eKit or back up pharmacy, for further recommendations with documentation in the electronic record. In-service also included how to order medications from pharmacy, obtaining medications from eKit and/or back up pharmacy. In-service will be completed by 12/22/2022. After 12/22/2022 any nurse who has not completed the in-service will complete prior to next scheduled work shift. All newly hired nurses will be in-service during orientation regarding	

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F 760	Continued From page 21 Attempts to interview Nurse #13 who was assigned Resident #13 on 5/6/2022 and 5/13/2022 were unsuccessful. On 11/17/2022 at 5:10 p.m. in an interview with Nurse #4, she stated the medication, Methotrexate, was reordered electronically using the electronic medical record system weekly after administering the scheduled dose. She stated if nursing staff did not reorder the medication, it would not be available the following week for administration. On 11/17/2022 at 5:25 p.m. in an interview with Resident #13, she stated there had been times when she did not get the Methotrexate injections and her hands would cramp when she did not receive the Methotrexate injection. She stated she could not recall the exact dates when she did not receive Methotrexate and did not understand why she had to wait a week if the medication was not available for administration. On 11/18/2022 at 3:03 p.m. in an interview with Nurse #7, she stated she reordered Resident #13's Methotrexate on 11/9/2022 by placing a sticker on a form for the medication and faxing to the pharmacy. On 11/18/2022 at 4:45 p.m. in an interview with the Operation Manager for Pharmacy, she stated pharmacy medication orders renewed were requested through the electronic medical record, and the pharmacy did not show receiving a fax or an order requesting Resident #13's Methotrexate medication since 11/9/2022. She stated in May 2022, pharmacy only showed an order to discontinue Methotrexate on 5/18/2022 and	F 760	Following Physician Orders. The Quality Assurance (QA) Nurse will audit 10 resident MARs to include resident #13 weekly x 4 week then monthly x 1 month utilizing the MAR Audit Tool. This audit is to ensure medications were administered per physician orders. The Unit Managers will address all concerns identified during the audit to include obtaining and administering medications per physician order, notification of the physician when medication does not arrive timely, cannot be obtained through the eKit or back up pharmacy, for further recommendations with documentation in the electronic record and/or re-training of staff. The Director of Nursing (DON) will review the MAR Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the MAR Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the MAR Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 760	Continued From page 22 re-ordered on 5/25/2022. On 11/18/2022 at 5:40 p.m. in an interview with the Director of Nursing, she stated Resident #13's Methotrexate medication should be re-ordered weekly through the electronic medical record system and documented when administered.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 761	F761 Label/Store Drugs and Biologicals	12/22/22

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F 761	Continued From page 23 facility failed to label insulin medication vials with a date the medication was opened and an expiration date on 2 of 5 medication carts observed (combined 800, 900 and 1100-hall and 700-hall medication cart) and failed to discard expired medications on 1 of 5 medication carts observed (combined 800, 900 and 1100-hall medication cart). The facility also failed to discard expired medications in 2 of 4 medication storage rooms (Station 4 and Station 1 medication storage room) inspected for storage of medications. Finding included: 1. a. An observation was conducted on 11/17/2022 at 2:28 p.m. of the combined 800, 900 and 1100-hall medication cart located in Station 4 in the presence of Nurse #1. An opened Lantus Insulin bottle dispensed from the pharmacy for Resident #128 was observed with no label indicating when the bottle of insulin was opened and there was no expiration date. An opened Humalog Insulin bottle dispensed from pharmacy for Resident #81 was observed labeled with an expiration date 10/22/22. There was no date on the Humalog Insulin label indicating when the medication was opened. In an interview with Nurse #1 on 11/17/2022 at 2:30 p.m., she stated she checked the combined 800, 900 and 1100-hall medication cart on 11/16/2022 for expirations. She stated the date Resident #128's vial of Lantus Insulin was opened should have been written on the label, and the expiration date, which should have been written on the label also, would have been twenty eight days after the opening date. She did not know when Resident #128's vial of insulin was	F 761	On 11/16/22, Nurse #1 removed and destroyed all medications that were not labeled with an open date and/or expiration date when indicated and all medication with an expired date to include insulin vials from the 800/900/1100 hall medication cart per facility protocol. On 11/17/22, Nurse #15 corrected the label for resident #36 insulin to reflect 11/16/22 as the open date and added the expiration date per facility protocol. On 11/17/22, Nurse #1 removed expired IV antibiotics for resident #36 and resident #336 from station 4 medication storage room and returned to pharmacy. On 11/17/22, Nurse #14 removed and discarded expired bottle of Docusate liquid from station 1 medication storage room. On 12/16/2022, the DON/Unit Managers initiated an audit of all medication carts and medication rooms to ensure the nurse labeled medication with an open date/expiration date when indicated and expired medications are removed/destroyed per facility protocol and/or returned to the pharmacy timely for destruction. The Unit Managers will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol, and returning expired or discontinued medications to the	

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F 761	Continued From page 24 opened and removed the vial of Lantus Insulin for Resident #128 from the combined 800, 900 and 1100-hall medication cart. Nurse #1 stated Resident #81 had been discharged from the facility last week, and the expired vial of Humalog Insulin for Resident #81 should had been removed from the combined 800, 900 and 1100-hall medication cart. Nurse #1 was observed removing the expired vial of Humalog Insulin for Resident #81 from the combined 800, 900 and 1100-hall medication cart. b. On 11/17/2022 at 2:48 p.m. an observation of 700-hall medication cart was conducted with Nurse # 15. An opened vial of Humulin 70/30 insulin for Resident #36 was observed with no opened date and expiration date on the label on the insulin vial and "expired in 28 days" was observed on the label. On 11/17/2022 at 2:48 p.m. in an interview with Nurse #15, she stated she opened the vial of Humulin 70/30 insulin for Resident #36 on 11/16/2022 and should have written the opened date on the vial of insulin. She stated sometimes the opened date and expiration dates of the insulin were written on the label of the plastic bottle the vial of insulin was dispensed in by the pharmacy. Resident #36's plastic bottle label was observed with 11/16/2022 written on the label with no information identifying what the date 11/16/2022 was representing. On 11/18/2022 at 4:41 p.m. in an interview with the Director of Nursing, she stated the label on the vial of insulin should be dated when opened and with an expiration dated of twenty-eight days after opening and expired medications should be returned to pharmacy.	F 761	pharmacy for destruction. The audit will be completed by 12/22/2022. On 12/16/2022, the DON initiated an in-service with all nurses regarding Medication Storage with emphasis on labeling medications with an open date/expiration date per facility protocol, responsibility to check medication cart/medication storage room daily for expired medications and discarding expired medications per pharmacy policy. In-service will be completed by 12/22/2022. After 12/22/2022 any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Medication Storage. The Unit Managers will audit all medication carts/medication storage rooms weekly x 4 weeks then monthly x 1 month utilizing the Medication Audit Tool. This audit is to ensure the nurse labeled medication with an open date/expiration date when indicated and expired medications are removed and destroyed per facility protocol. The Unit Managers will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated and removing expired medications per facility protocol. The Director of Nursing (DON) will review Medication Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. for completion and to ensure all areas of concerns were.	

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F 761	Continued From page 25 2. a. An observation of the facility's Station 4 medication storage room was conducted on 11/17/2022 at 2:40 p.m. with Nurse #1. Eight Ampicillin, an antibiotic medication, bulbs for intravenous (IV) administration for Resident #95 were observed in a large clear bag dated by pharmacy issued on 11/11/22 with an expiration date of 11/14/2022. Another eight Ampicillin IV bulbs for Resident #95 were observed in another large clear bag dated by the pharmacy issued on 11/13/2022 with an expiration date of 11/16/2022. Three Ampicillin 2 grams IV bulbs dated issued by the pharmacy on 11/7/2022 with an expiration date of 11/10/2022 were observed in a clear bag for Resident #336 in the refrigerator. On 11/17/2022 at 2:40 p.m. in an interview with Nurse #1, she stated Resident #95 was receiving IV antibiotics every four hours and she checked the expiration date on the label of the Ampicillin bulbs prior to administering the IV antibiotics. She stated she was not assigned to Resident #336. Nurse #1 removed the expired Ampicillin bulbs from the refrigerator for Resident #36 and Resident #336 to return to the pharmacy. b. On 11/17/2022 at 3:04 p.m. an observation of the facility's Station 1 medication storage room was conducted with Nurse #14. An unopened bottle of Docusate Liquid 50 milligrams per 5 milliliters was observed at the front of a medication shelf with 4/2022 as the expiration date. Nurse #14 removed the bottle of Docusate Liquid from the medication room to return to the pharmacy. On 11/17/2022 at 3:04 p.m. in an interview with Nurse #14, she stated the medication room and	F 761	The DON will present the findings of the Medication Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 761	Continued From page 26 medications in the refrigerator were checked daily and she checked medications for expirations prior to administering to the residents. She stated Nurse #10 checked the medication room for expirations on 11/16/2022. On 11/17/2022 at 3:10 p.m. in an interview with Nurse #10, she stated she checked Station 1 medication storage room on 11/16/2022 and it was an oversight and missed the expired bottle of Docusate Liquid. On 11/18/2022 at 4:41p.m. in an interview with the Director of Nursing, she stated medication storage rooms were checked daily by unit managers and nurses and was unsure why expired medications were in the medication rooms on 11/17/2022. She stated expired medication should be returned to the pharmacy.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implement procedures and monitor for interventions the committee put into place following the recertification and complaint survey conducted on 7/29/2021 and 2/14/2020 for two deficiencies cited in the areas of Pharmacy	F 867	F867 QAPI/QAA Improvement Activities On 12/16/2022, the Administrator initiated an audit of previous citations and action plans from 2/1/20 to 12/1/2022 to include F761 Pharmacy Services and F880 infection control to ensure the QA	12/22/22

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F 867	Continued From page 27 Services (F761) and Infection Control (F880). The duplication of citations during multiple federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Finding included: This tag is cross reference to: F-761 Based on observations and staff interviews, the facility failed to label insulin medication vials with a date the medication was opened and an expiration date on 2 of 5 medication carts observed (combined 800, 900 and 1100-hall and 700-hall medication cart) and failed to discard expired medications on 1 of 5 medication carts observed (combined 800, 900 and 1100-hall medication cart). The facility also failed to discard expired medications in 2 of 4 medication storage rooms (Station 4 and Station 1 medication storage room) inspected for storage of medications. During the recertification and complaint survey of 2/14/2020 the facility failed to dispose of expired drugs or biologicals on one of four medication carts inspected for expired medications (400 hall medication cart). F-880 Based on observations, record review, and staff interviews, the facility failed to perform hand hygiene after removing a dirty dressing with drainage on it and before cleansing the wound with wound cleanser-soaked gauze and applying a clean dressing for 1 of 1 nurse reviewed for wound care (Treatment Nurse #1). During the recertification and complaint survey of	F 867	committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by Quality Assurance (QA) Nurse for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to education of staff. Audit will be completed by 12/22/2022 On 12/19/2022, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist and Quality Assurance (QA) Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include pharmacy services and infection control. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 12/22/2022. All newly hired Administrator, DON, ADON, Infection Preventionist and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns to include infection control will be taken to the Quality Assurance	

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F 867	Continued From page 28 7/29/2021 the facility failed to implement the facility 's infection control measures for the quarantine unit when 1) Nurse # 2 was observed entering a resident 's room wearing only an N-95 mask for 1 of 21 residents on the 1000 hall of the quarantine unit, a Social Worker was observed entering a resident 's room wearing only an N-95 and an isolation gown on the 1100 hall of the quarantine unit, and the Nurse Aide #2, Social Worker and Physician were observed exiting 3 of 21 residents rooms on the 1100 hall quarantine unit wearing the isolation gowns and removing the isolation in the hallway of the quarantine unit, 2) change a peripherally inserted central catheter (PICC) dressing weekly as ordered by the physician for 1 of 1 resident (Resident# 111) reviewed, and 3) maintain social distancing in the smoking area for 2 of 2 residents reviewed. (Residents # 69, #76) This occurred during the COVID pandemic. During the recertification and complaint survey of 2/14/2020 the facility failed to wash hands with soap and water prior to exiting the room for 1 of 1 resident on contact precautions for Clostridium Difficile. (Resident # 168) In an interview with the Administrator on 11/18/2022 at 5:39 p.m. with the Regional Nursing Consultant present, the Administrator stated the unit managers conducting weekly audits on the medication storage rooms and monthly audits were conducted on the medication storage rooms, medication carts and on narcotics storage. She stated the supervisor on the night shift randomly checked the medication carts for expired medications. She stated the facility had conducted in-services on handwashing during the COVID pandemic and continued to monitor	F 867	committee for review monthly x 3 months by the QA Nurse. The Quality Assurance committee will review the data and determine if plan of corrections is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include infection control and all current citations and QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON, ADON, Infection Preventionist and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Quality Assurance Nurse to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	

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F 867	Continued From page 29 handwashing. She stated the Quality Improvement (QI) team monitored pressure wounds and the care provided to assure correct procedures were in place for the care of the wound. The Regional Nursing Consultant stated when the consultant team visited the facility each month, medication storage rooms and medications carts were checked by the consultant team for compliance and conducted observations of wound care. The Administrator and Regional Nurse Consultant stated no concerns were identified with the audits for medication storage on the medication carts, in the medication storage room and handwashing during wound care.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		12/22/22

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F 880	Continued From page 30	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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	345113	A. BUILDING _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to perform hand hygiene after removing a dirty dressing with drainage on it and before cleansing the wound with wound cleanser-soaked gauze and applying a clean dressing for 1 of 1 nurse reviewed for wound care (Treatment Nurse #1). Findings included: Review of the facility's infection control policy, "Handwashing/Hand Hygiene" read in part, "Good hand hygiene is essential and is the primary means to prevent the spread of infection. Alcohol-based handrubs (ABHR) may be substituted when soap and water is not indicated. It listed in part that handwashing/hand hygiene should be performed immediately after gloves are removed and when moving from a contaminated body site to a clean body site such as when changing a brief or wound dressing. An observation of wound care by Treatment Nurse #1 was completed on 11/17/2022 at 1:48 PM. Treatment Nurse #1 gathered her dressing supplies on a piece of wax paper and washed her hands and donned gloves. Nurse Assistant #2 assisted the resident to roll on her right side, so the wound would be exposed on the left buttock. Treatment Nurse #1 removed the old dressing which had a small amount of serous drainage on it and disposed of it in plastic bag. Treatment	F 880	F880 Infection Prevention & Control On 11/17/22, the Director of Nursing (DON) immediately educated the treatment nurse #1 regarding hand hygiene to include hand hygiene between glove change and when moving from dirty to clean wound care activities. On 11/17/2022, the Infection Preventionist and Quality Assurance Nurse initiated Resident Care Audit-Hand Hygiene with all nurses providing wound care. This audit was to ensure staff used appropriate hand hygiene between glove change and when moving from dirty to clean wound care activities. The Infection Preventionist and QA nurse will address all concerns identified during the audit to include education of the nurse. Audit will be completed by 12/22/2022. After 12/22/2022, any nurse who has not worked or completed the resident care audit will complete on next scheduled work shift. On 12/16/2022, the Infection Preventionist and Director of Nursing initiated an in-service with all nurses regarding Hand Hygiene with emphasis on hand hygiene between changing gloves and when	

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F 880	Continued From page 32 Nurse #1 cleansed the wound with wound cleanser on gauze, loosely packed the wound with calcium alginate, and applied an absorbent dressing. She secured the dressing with paper tape that had been lying on the resident's bed and then put it in her pocket. Treatment Nurse #1 then removed her gloves, disposed of dirty supplies, and then washed her hands. An interview with Treatment Nurse #1 occurred on 11/17/2022 at 2:15 PM. Treatment Nurse #1 stated that she was nervous and forgot to change her gloves during the dressing change. She further stated that the paper tape was used for other residents' dressing changes. An interview was completed with the Director of Nursing on 11/17/2022 at 3:40 PM. The DON stated the facility's Infection Preventionist (IP) had quit 2 weeks ago, and she was filling in until the new IP started. She further stated that Treatment Nurse # 1 was new to the facility, and she was probably nervous because of the surveyor observing the dressing change. She further indicated that Treatment Nurse #1 should have changed her gloves and performed hand hygiene after removing the old dressing and prior to applying the new dressing. The DON stated that if the tape was laying on the resident's bed, then it should be designated for that resident and not shared with other residents.	F 880	moving from dirty to clean wound care activities. In-service will be completed by 12/22/22. After 12/22/2022, any nurse who has not worked or received the in-service will complete prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Hand Hygiene. The Infection Preventionist and/or Assistant Director of Nursing (ADON) will complete 5 Resident Care Audit-Hand Hygiene with all nurses providing wound care weekly x 4 weeks then monthly x 1 month. This audit is to ensure staff used appropriate hand hygiene between glove change and when moving from dirty to clean wound care activities. The Infection Preventionist/ADON will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the Resident Care Audit-Hand Hygiene weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing (DON) will present the findings of the Resident Care Audit-Hand Hygiene to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Care Audit-Hand Hygiene to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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